Texas Board of Physical Therapy Examiners

333 Guadalupe, Suite 2-510 ***512/305-6900***
Austin, Texas 78701-3942 ***www.ptot.texas.gov***

Compact Privilege Practice Location

Name: _____ **TX Compact Privilege Number:** _____

Phone: _____ **Email:** _____

During the time I am practicing physical therapy under a Compact Privilege in Texas, I will be practicing at the following facility(ies). **Indicate if services will be provided via telehealth.**

Name of Facility (1):_____

Address of Facility:_____

_____

City: _____ **State:** _____ **Zip:**_____

Facility Phone #: _____

_____

Name of Facility (2):_____

Address of Facility:_____

_____

City: _____ **State:** _____ **Zip:**_____

Facility Phone #: _____

_____

Name of Facility (3):_____

Address of Facility:_____

_____

City: _____ **State:** _____ **Zip:**_____

Facility Phone #: _____

_____

If more than 3 facilities, complete an additional form.

_____

Signature

Submit completed form(s) to emailpt@ptot.texas.gov or mail to address above.